# Technical Assistance Guide

# for the

# Focused Review of Parity Act Compliance

# of

# Full Service Plans

## May 3, 2005

# PREFACE

This protocol document, *Technical Assistance Guide for the Focused Review of Parity Act Compliance of Full Service Plans,* will be used by the Department of Managed Health Care (DMHC) to conduct an initial assessment and ongoing monitoring of health plans' implementation of California's Mental Health Parity Act. [Section 1374.72. Rule 1300.74.72.]

Health and Safety Code Section 1374.72, often referred to as the "Parity Act," requires health plans to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions. Rule 1300.74.72 requires health plans to provide timely access and referral for diagnosis and treatment of Section 1374.72 services. Additionally, the Rule requires full service health plans which contract with behavioral health plans to monitor the collaboration between medical and mental health plans and to assure continuity and coordination of enrollee care.

This document, dated May 3, 2005, will be used for the surveys of Full Service Plans subsequent to the two pilot surveys.

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# ACCESS AND AVAILABILITY OF SERVICES

| Item | Requirement |
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| **AA-001** | **Communication of Benefits Information**<br>The Plan communicates information about both parity and non-parity mental health benefits clearly and accurately to its enrollees and prospective enrollees. |
| | ***Statutory/Regulatory Citation(s):*** |
| | **CA Health and Safety Code 1374.72 (a)-(e)**<br><br>(a) Every health plan contract issued, amended, renewed on or after July 1, 2000, that provides hospital, medical or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).<br><br>(b) These benefits shall include the following:<br>(1) Outpatient services.<br>(2) Inpatient hospital services.<br>(3) Partial hospital services.<br>(4) Prescription drugs, if the plan contract includes coverage for prescription drugs.<br><br>(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:<br>(1) Maximum lifetime benefits.<br>(2) Copayments.<br>(3) Individual and family deductibles.<br><br>(d) For the purposes of this section, "severe mental illnesses" shall include:<br>(1) Schizophrenia.<br>(2) Schizoaffective disorder.<br>(3) Bipolar disorder (manic-depressive illness).<br>(4) Major depressive disorders.<br>(5) Panic disorder.<br>(6) Obsessive-compulsive disorder.<br>(7) Pervasive developmental disorder or autism<br>(8) Anorexia nervosa<br>(9) Bulimia nervosa<br><br>(e) For purposes of this section a child suffering from "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical |

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Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

**Welfare and Institutions Code 5600.3(a)(2)**

(2) For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

**28 CCR 1300.74.72(a)**

The mental health services required for the diagnosis and treatment of conditions set forth in Health and Safety Code section 1374.72 shall include, when medically necessary, all health care services required under the Act including, but not limited to, basic health care services within the meaning of Health and Safety Code sections 1345(b) and 1367(i), and section 1300.67 of Title 28. These basic health care services shall, at a minimum, include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from licensed mental health providers including, but not limited to, psychiatrists and psychologists.

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**28 CCR 1300.74.72(e)**

"Pervasive Developmental Disorders shall include Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's and Pervasive Developmental Disorder Not Otherwise Specified (including Atypical Autism), in accordance with the Diagnostic and Statistical Manual for Mental Disorders—IV—Text Revision (July 2000)

**28 CCR 1300.74.72(i)**

A plan shall include in its Evidence of Coverage or Combined Evidence of Coverage and Disclosure Form a list of mental conditions required to be covered pursuant to Health and Safety Code section 1374.72.

**28 CCR 1300.63.2 (c) (14)**

The combined evidence of coverage and disclosure form shall contain at a minimum the following information:
(14) The exact procedure for obtaining benefits, including the procedure for filing claims…

**28 CCR 1300.74.72(g)**

If a plan contracts with a specialized health care service plan for the purpose of providing Health and Safety Code section 1374.72 services, the following requirements shall apply:

(1) the specialized health care service plan shall maintain a telephone number that an enrollee may call during normal business hours to obtain information about benefits, providers, coverage and any other relevant information concerning an enrollee's mental health services.

(2) if the plan issues identification cards to enrollees, the identification cards shall include the telephone number required to be maintained above and a brief statement indicating that enrollees may call the telephone number for assistance about mental health services and coverage.

**28 CCR 1300.67.2. (g)**

(g) A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that plan or area.

***Standards for Meeting Statutory/Regulatory Requirements:***

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| **AA-001** | **Communication of Benefits Information**<br>The Plan communicates information about both parity and non-parity mental health benefits clearly and accurately to its enrollees and prospective enrollees. |

1. **Standard:** The Plan's Evidence of Coverage or Combined Evidence of Coverage and Disclosure Form and the Schedule of Benefits accurately and clearly describe benefit coverage for mental health parity diagnoses/conditions, distinguish between parity and non-parity mental health benefits, if applicable, and describe how enrollees can obtain both parity and non-parity mental health benefits.

**Guidance:**

1.1 Review the Evidence of Coverage or Combined Evidence of Coverage and Disclosure Form and, if applicable, the Schedule of Benefits. Determine whether the Plan provides parity for those diagnoses and conditions as specified in subdivision (d) of Section 1374.72. Review the description of the mental health benefits to verify the following:

(a) There is a clear description of the nine severe mental illnesses that are listed in Section 1374.72(d).

(b) There is a clear description of "serious emotional disturbances of a child" that is consistent with Section 1374.72(e) and Rule 1300.74.72(a).

(c) There is a clear description of how the Plan or its Delegate, if applicable, determines whether an enrollee's mental health diagnosis/condition is one of the parity diagnoses/conditions.

(d) The maximum lifetime benefits, co-payments and individual and family deductibles are the same for the parity mental health benefits as for medical benefits for outpatient services, inpatient hospital services, partial hospital services, and prescription drugs, if the Plan contract includes coverage for prescription drugs.

1.2 Review the Evidence of Coverage or the Combined Evidence of Coverage/Disclosure Form to determine if it contains the following information:

(a) differences, if any, in how to obtain parity and non-parity mental health benefits;

(b) how to obtain mental health benefits provided by primary care practitioners;

(c) how to obtain mental health benefits provided by mental health practitioners and/or programs, including services provided by delegates, if applicable;

(d) whether a referral by the enrollee's primary care practitioner is required and if so, how to obtain the referral; and

(e) the telephone number to call for the enrollee to obtain more

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| AA-001 | **Communication of Benefits Information**<br>The Plan communicates information about both parity and non-parity mental health benefits clearly and accurately to its enrollees and prospective enrollees. |

information about mental health benefits and how to access those benefits.

**Documents to be Reviewed:**

- Evidence of Coverage or Combined Evidence of Coverage and Disclosure Form (for each applicable product line)
- Schedule of Benefits (for each applicable product line)

**Individual(s)/Positions to be Interviewed:**

- Compliance Officer
- Person responsible for management of mental health benefits

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2. **Standard:** Marketing materials and enrollee educational materials accurately present benefit coverage for parity diagnoses/conditions and clearly distinguish between parity and non-parity mental health benefits, if applicable.

**Guidance:**

2.1 Review marketing materials, if different from enrollment materials, and enrollee education materials for accuracy and clarity. Determine whether the Plan provides parity for those diagnoses and conditions as specified in subdivisions (d) and (e) of Section 1374.72. Review the description of the mental health benefits to verify the following:

(a) For parity mental illnesses:

(1) There is a clear description of the nine parity diagnoses listed in Section 1374.72(d).

(2) There is a clear description of "serious emotional disturbances of a child" that is consistent with Section 1374.72(e) and Rule 1300.74.72(a).

(3) There is a clear description of how the Plan or its Delegate, if applicable, determines whether an enrollee's mental health condition is one of the parity conditions.

(4) There is a clear description of excluded and limited mental health services, if any.

(5) The maximum lifetime benefits, co-payments and individual and family deductibles are the same for the parity mental health benefits as for medical benefits for outpatient services, inpatient hospital services, partial hospital services, and prescription drugs, if the Plan contract includes coverage for prescription drugs.

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(b) For non-parity mental illnesses:
  (1) There is a clear description of the covered non-parity mental illnesses.
  (2) There is a clear description of excluded and limited mental health services, if any.
  (3) There is a clear description of maximum lifetime benefits, co-payments and individual and family deductibles for outpatient services, inpatient hospital services, partial hospital services, and prescription drugs, if the Plan contract includes coverage for prescription drugs.

**Documents to be Reviewed:**

- Marketing materials, such as summaries of benefits, and presentation materials, such as PowerPoint presentations
- Enrollee education materials from the Plan and, if applicable, the Delegate. These may include brochures on mental health services and enrollee newsletters that contain articles on mental health benefits and services.

**Individual(s)/Positions to be Interviewed:**

- Compliance Officer

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**3. Standard:** The Plan includes on the enrollee's ID card the telephone number that enrollees should call to obtain information about mental health coverage and services.

If the Plan contracts with a specialized mental health service plan (Delegate) for the purpose of providing Health and Safety Code Section 1374.72 services, the Plan includes the specialized mental health service plan's telephone number on the ID card with a brief statement that the enrollee should call this number to obtain information about mental health coverage and services.

**Guidance:**

3.1 Review the enrollee ID card. Verify that the ID card contains a telephone number that enrollees should call to obtain information about mental health coverage and services.

**Documents to be Reviewed:**

- Sample enrollee identification card for each applicable product line

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| AA-001 | **Communication of Benefits Information**<br>The Plan communicates information about both parity and non-parity mental health benefits clearly and accurately to its enrollees and prospective enrollees. |

**Individual(s)/Positions to be Interviewed:**

None

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4. **Standard:** The Plan maintains a telephone number during normal business hours to respond to enrollee requests for information about mental health benefits. If the Plan contracts with a specialized health care service plan for the purpose of providing Health and Safety Code section 1374.72 services, the Plan requires the Delegate to provide and maintain this number.

**Guidance:**

4.1 Call the number that is listed on the enrollee's identification card for mental health benefits to verify that:

(a) The Plan or Delegate provides a telephone line that enrollees can access to obtain information about mental health benefits and how to obtain those benefits.

(b) The Plan or Delegate appropriately responds to callers in a timely manner. Verify that the Plan's or Delegate's telephone answering and routing system does not subject callers to unreasonable hold times and/or a complicated routing system. The Plan or Delegate provides adequate and correct information.

**Documents to be Reviewed:**

- Sample enrollee identification card for each affected product line

**Individual(s)/Positions to be Interviewed:**

- None

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5. **Standard:** Member/Customer Services staff accurately present mental health benefit coverage and information about how to obtain mental health services for parity and non-parity conditions.

**Guidance:**

5.1 Review the Customer/Member Services guidance materials (e.g., policies and procedures, scripts, training materials) to verify that they accurately and clearly present the Plans mental health benefit structure and information on how to access mental health services both for parity and non-parity conditions.

(a) Determine whether the Plan provides parity for those

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diagnoses and conditions as specified in subdivisions (d) and (e) of Section 1374.72. Review the description of the mental health benefits to verify the following:

- There is a clear description of the mental health benefits.
- There is a clear description of excluded and limited mental health services, if any.
- There is a clear description of "serious emotional disturbances of a child" that is consistent with Section 1374.72(e) and Rule 1300.74.72(a)
- The maximum lifetime benefits, co-payments and individual and family deductibles are the same for mental health benefits as for medical benefits for outpatient services, inpatient hospital services, partial hospital services, and prescription drugs, if the Plan contract includes coverage for prescription drugs.

(b) Review the description of the mental health benefits. Verify the following:

- For the parity mental illnesses:
  - There is a clear description of the nine severe mental illnesses that are listed in Section 1374.72(d).
  - There is a clear description of excluded and limited mental health services, if any.
  - There is a clear description of "serious emotional disturbances of a child" that is consistent with Section 1374.72(e) and Rule 1300.74.72(a).
  - There is a clear description of how the Plan or its specialized mental health care service plan, if applicable, determines whether an enrollee's mental health condition is one of the parity conditions.
  - The maximum lifetime benefits, copayments and individual and family deductibles are the same for the parity mental health benefits as for medical benefits for outpatient services, inpatient hospital services, partial hospital services, and prescription drugs, if the Plan contract includes coverage for prescription drugs.
- For non-parity mental illnesses:
  - There is a clear description of the covered non-parity mental illnesses.
  - There is a clear description of excluded and limited

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mental health services, if any.

- There is a clear description of maximum lifetime benefits, copayments and individual and family deductibles for outpatient services, inpatient hospital services, partial hospital services, and prescription drugs, if the Plan contract includes coverage for prescription drugs.

**Documents to be Reviewed:**

- Scripts, computer screens, and other materials that Member/Customer Service staff use to respond to enrollee inquiries about mental health coverage
- Review reports of supervisory audits and monitoring of Customer/Member Services staff to determine whether accuracy of information regarding parity is being monitored and to assess findings.

**Individual(s)/Positions to be Interviewed:**

- Person responsible for Member/Customer Services
- One or more Member/Customer Services representatives

***Level of Compliance:***

Met: All statutory/regulatory requirements are met.
Not Met: Some or not all statutory/regulatory requirements are met.

| Item | Requirement |
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| **AA-002** | **Mental Health Provider Availability Standards**<br>The Plan ensures that its network of mental health providers is adequate to meet the mental health needs of its enrollees. |
| | ***Statutory/Regulatory Citation(s):*** |

**28 CCR 1300.74.72(b)**

(b) A health plan shall provide coverage for the diagnosis, and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 through health care providers within the meaning of Health and Safety Code section 1345(i) who are:
(1) acting within the scope of their licensure, and
(2) acting within their scope of competence, established by education, training and experience, to diagnose, and treat conditions set forth in Health and Safety Code section 1374.72.

**CA Health and Safety Code Section 1345(i)**

(i) "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

**28 CCR 1300.67.2. (b)-(f)**

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees; …

(b) Hours of operation and provision for after-hour services shall be reasonable;

(c) Emergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week;

(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;

(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral;

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| **AA-002** | **Mental Health Provider Availability Standards**<br>The Plan ensures that its network of mental health providers is adequate to meet the mental health needs of its enrollees. |

(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments; …

Subject to subsections (a) and (b) of this section, a plan may rely on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.

**28 CCR 1300.67.2.1.(a)**

Subject to subsections (a) and (b) of this section, a plan may rely on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.

(a) If a plan believes that, given the facts and circumstances with regard to any portion of its service area, the standards of accessibility set forth in Item H of Section 1300.51 and/or Section 1300.67.2 are unreasonably restrictive, the plan may propose alternative standards of accessibility for that portion of its service area. The plan shall do so by including such alternative standards in writing in its plan license application or in a notice of material modification….

***Standards for Meeting Statutory/Regulatory Requirements:***

1. **Standard:** The Plan has implemented standards for the number and geographic distribution of mental health providers by type and measures the adequacy of its network against its standards at least annually.

   At a minimum, the Plan has standards and conducts analysis/follow-up for the following types of practitioners:

   - Psychiatrists that treat adults
   - Psychiatrists that treat children and adolescents
   - Other prescribing clinicians (e.g., mental health nurse practitioner with furnishing number) that treat adults
   - Other prescribing clinicians (e.g., mental health nurse practitioner with furnishing number) that treat children and adolescents
   - Doctoral level psychologists that treat adults
   - Doctoral level psychologists that treat children and adolescents
   - Master's prepared mental health clinicians (e.g., MFT, LCSW) that treat adults
   - Master's prepared mental health clinicians (e.g., MFT, LCSW) that treat children and adolescents

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| **AA-002** | **Mental Health Provider Availability Standards**<br>The Plan ensures that its network of mental health providers is adequate to meet the mental health needs of its enrollees. |

**Guidance:**

1.1 Geographic distribution can be expressed as either driving time or distance in miles from a provider of each type. The Plan can have different standards for urban and rural areas in the state.

1.2 The Plan analyzes the needs of its enrollee population for each of its service areas or, in the case of multi-county service areas, for each county within the service area. If the Plan identifies shortcomings in its network of clinicians, it takes appropriate corrective action and re-measures until it meets its standards.

1.3 Review documentation that demonstrates that the Plan has established geographic distribution standards for various mental health providers and measures its network against those standards.

1.4 Review documentation or reports that display, by county and by provider type, the number of providers contracting with the Plan vs. the number of providers available to help assess barriers to contracting.

**Documents to be Reviewed:**

- Reports that demonstrate that the Plan has numeric and geographic distribution standards and measures its network against the standards at least annually.
- Reports that demonstrate that, if the Plan found shortcomings in its network of clinicians, it has taken action to remedy those shortcomings and has re-measured.

**Individual(s)/Positions to be Interviewed:**

- Person responsible for maintaining the mental health network

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2. **Standard:** The Plan has implemented a process to verify periodically that participating providers are accepting new enrollees and takes this information into account when monitoring the adequacy of its network. At a minimum, this process includes the following types of practitioners:

   - Psychiatrists that treat adults
   - Psychiatrists that treat children and adolescents
   - Other prescribing clinicians (e.g., mental health nurse practitioner with furnishing number) that treat adults
   - Other prescribing clinicians (e.g., mental health nurse practitioner with furnishing number) that treat children and adolescents

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| **AA-002** | **Mental Health Provider Availability Standards**<br>The Plan ensures that its network of mental health providers is adequate to meet the mental health needs of its enrollees. |

- Doctoral level psychologists that treat adults
- Doctoral level psychologists that treat children and adolescents
- Master's prepared mental health clinicians (e.g., Clinical Psychologist, MFT, LCSW) that treat adults
- Master's prepared mental health clinicians (e.g., Clinical Psychologist, MFT, LCSW) that treat children and adolescents

**Guidance:**

2.1 Review documentation that demonstrates that the Plan has established standards for the percent of open practices for mental health clinicians and measures its network against those standards.

2.2 Randomly select 40 clinicians for each provider type from the Plan's list of available providers (with open practices). Conduct a telephone survey of these provider offices to determine whether they are currently participating with the Plan, are accepting new patients and have appointment availability consistent with the Plan's standards.

**Documents to be Reviewed:**

- Reports that demonstrate that the Plan has standards regarding open practices and measures its network against the standards at least annually.
- Reports that demonstrate that, if the Plan found shortcomings in its network of clinicians, it has taken action to remedy those shortcomings and has re-measured the status of the network.

**Individual(s)/Positions to be Interviewed:**

- Person responsible for maintaining the mental health network

***Level of Compliance:***

Met: All statutory/regulatory requirements are met.
Not Met: Some or not all statutory/regulatory requirements are met.

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| **AA-003** | **Mental Health Facility and Program Availability**<br>The Plan has an adequate network of mental health facilities and treatment/special service programs to meet the mental health needs of its enrollees. |

***Statutory/Regulatory Citation(s):***

**28 CCR 1300.74.72(a)**

These basic health care services shall, at a minimum, include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services….

***Standards for Meeting Statutory/Regulatory Requirements:***

1. **Standard:** The Plan has implemented geographic distribution standards and related goals for mental health facilities and service programs by type and measures the adequacy of its network against its standards at least annually. At a minimum, the Plan has geographic distribution standards and related goals for the following types of facilities and programs:
   - Crisis services/intervention/outreach
   - Voluntary inpatient admission
   - Involuntary inpatient admission
   - Partial hospitalization/day hospitalization
   - Intensive outpatient treatment
   - Specialized treatment programs (e.g., behavior modification, eating disorders, autism)
   - Other facilities/program, consistent with the scope of covered benefits

**Guidance:**

1.1 The Plan conducts an analysis for each of its service areas or, in the case of multi-county service areas, for each county within the service area. Geographic distribution may be expressed as either driving time or distance in miles from a facility of each type. The Plan may have different standards for urban and rural areas in the state.

1.2 Review documentation that demonstrates that the Plan has established geographic distribution standards for mental health facilities and programs and measures its network against those standards.

1.3 If the Plan states that it provides any of these services through referral to county mental health facilities and/or programs, review the contract(s) between the Plan and the county for these services

1.4 Interview case management staff. Verify that there are adequate facilities and service programs for each level and type of mental health service within the enrollees' service areas.

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| **AA-003** | **Mental Health Facility and Program Availability**<br>The Plan has an adequate network of mental health facilities and treatment/special service programs to meet the mental health needs of its enrollees. |
| | **Documents to be Reviewed:**<br>• Reports that demonstrate that the Plan has standards and measures its network against the standards at least annually.<br>• Reports that demonstrate that, if the Plan found shortcomings in its network of clinicians, it has taken action to remedy those shortcomings and has re-measured.<br><br>**Individual(s)/Positions to be Interviewed:**<br>• Person responsible for maintaining the mental health network<br>• Case management staff (can be nurse case manager or social worker or other clinical staff person designated by Plan as case manager) |
| | ***Level of Compliance:*** |
| | Met: All statutory/regulatory requirements are met.<br>Not Met: Some or not all statutory/regulatory requirements are met. |

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| **AA-004** | **Mental Health Provider Appointment Availability**<br>The Plan ensures adequate and timely appointment availability to meet the mental health needs of enrollees. |

***Statutory/Regulatory Citation(s):***

**28 CCR Rule 1300.74.72(f)**

A health plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set for in Health and Safety Code section 1374.72…

**CA Health and Safety Code 1374.72(g)(3)**

Notwithstanding any other provision of law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, co-payments, or other cost sharing.

**28 CCR 1300.74.72(b)**

b) A plan shall provide coverage for the diagnosis, and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 through health care providers within the meaning of Health and Safety Code section 1345(i) who are:
(1) acting within the scope of their licensure, and
(2) acting within their scope of competence, established by education, training and experience, to diagnose, and treat conditions set forth in Health and Safety Code section 1374.72.

**28 CCR 1300.67.2. (f)**

f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments;

***Standards for Meeting Statutory/Regulatory Requirements:***

1. **Standard:** The Plan has established standards for appointment availability for adults, adolescents, and children by type of appointment and type of provider and measures appointment availability against its standards at least annually.

   At a minimum, the standards and related goals include the following types of appointments for both psychiatrist and non-psychiatrist clinicians, as appropriate to the clinician's scope of license: non-life-threatening

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| **AA-004** | **Mental Health Provider Appointment Availability**<br>The Plan ensures adequate and timely appointment availability to meet the mental health needs of enrollees. |

emergency appointment; urgent appointment; routine appointment; post-hospital discharge appointment (applies to prescribing clinicians only) for adults, adolescents, and children. Standards should address both appointments made through the telephone triage and referral system and those made through other means (e.g., post-discharge appointments made by providers, self-referrals).

The Plan monitors appointments availability to ensure that enrollees receive appropriate appointments within its. If the Plan identifies areas in which there is not adequate appointment availability, it takes action to improve appointment availability and re-measures**.**

**Guidance:**

1.1 Review documents that demonstrate that the Plan has established appointment availability standards and related goals for psychiatrist and non-psychiatrist clinicians by type of appointment for adults, adolescents, and children. Examples of standards are:

- Non-life-threatening emergency appointment: within 6 hours
- Urgent appointment: within 48 hours
- Routine appointment: within 10 business days
- Post-hospital discharge appointment with a prescribing clinician: within 7 calendar days or earlier if patient needs prescriptions to be rewritten.

1.2 Review documentation that the Plan conducts an analysis at least annually for each of its service areas or, in the case of multi-county service areas, for each county within the service area. If the Plan identifies areas in which there is not adequate appointment availability, it takes action to improve appointment availability and re-measures.

1.3 If the Plan has not met its standards for appointment availability in some or all of its service areas, review documents that demonstrate that the Plan has taken corrective action and has re-measured.

1.4 Conduct the survey of 40 randomly selected providers described under AA-002, Guidance 2.2 to evaluate the availability of routine appointments against the Plan's standard for routine appointments. If there is no one available in the office at the time of the call, leave a message for a call-back.

| Item | Requirement |
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| **AA-004** | **Mental Health Provider Appointment Availability**<br>The Plan ensures adequate and timely appointment availability to meet the mental health needs of enrollees. |

**Documents to be Reviewed:**

- Policies and procedures or other documentation that demonstrate that the Plan has established appointment availability standards and related goals for psychiatrist and non-psychiatrist clinicians by type of appointment.
- Reports that demonstrate that the Plan monitors the timeliness of appointment availability.
- Reports that demonstrate that, if the Plan did not meet its goals for appointment availability in some or all of its service area, it has taken action to remedy those shortcomings and has re-measured.

**Individual(s)/Positions to be Interviewed:**

- Person responsible for maintaining the mental health network
- Person responsible for managing the triage and referral process
- Plan Director of Quality Improvement

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2. **Standard:** The Plan or Delegate has established standards and goals for timeliness of response to its triage and referral telephone lines and measures its performance against these standards and goals at least quarterly. If the Plan does not meet its goals, it takes corrective action and re-measures.

**Guidance:**

2.1 Review documentation that demonstrates that the Plan has established timeliness standards and monitors the timeliness of answering its triage and referral telephones. Examples of timeliness standards include average speed of answer to a non-recorded voice and abandonment rate.

2.2 Review documentation that demonstrates that, if the Plan does not meet its goals, the Plan takes action to improve the timeliness of answering the triage and referral telephones and re-measures.

**Documents to be Reviewed:**

- Reports that demonstrate that the Plan monitors the timeliness of answering the triage and referral telephone phones.
- Reports and corrective action plans that demonstrate that, if the Plan did not meet its goals for timeliness of answering the triage and referral telephone, it has taken action to improve its performance and has re-measured.

| Item | Requirement |
|---|---|
| **AA-004** | **Mental Health Provider Appointment Availability**<br>The Plan ensures adequate and timely appointment availability to meet the mental health needs of enrollees. |
| | **Individual(s)/Positions to be Interviewed:**<br>• Person responsible for managing the triage and referral process<br>• Triage and referral staff person responsible for answering calls |
| | ***Level of Compliance:*** |
| | Met: All statutory/regulatory requirements are met.<br>Not Met: Some or not all statutory/regulatory requirements are met. |

| Item | Requirement |
|---|---|
| **AA-005** | **After-Hours Services**<br>The Plan's provisions for after-hours services are reasonable. |

***Statutory/Regulatory Citation(s)***

**28 CCR 1300.67.2(b)**

Hours of operation and provision for after-hour services shall be reasonable.

**28 CCR 1300.74.72(f)**

A health plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set for in Health and Safety Code section 1374.72…

**28 CCR 1300.67.2. (b)**

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees; …

(b) Hours of operation and provision for after-hour services shall be reasonable;

***Standard for Meeting Statutory/Regulatory Requirements***

1. **Standard:** The Plan has established standards that ensure after-hours care coverage. The Plan monitors after-hours coverage and, if the Plan identifies areas in which there is not adequate after-hours coverage, it takes action to improve appointment availability and re-measures**.**

**Guidance:**

1.1 Review documents that demonstrate that the Plan has established standards and related goals for after-hours coverage.

1.2 Review documentation that the Plan conducts an analysis at least annually of after-hours coverage by provider type.

1.3 If the Plan has not met its standards for appointment availability in some or all of its service areas, review documents that demonstrate that the Plan has taken corrective action and has re-measured.

1.4 Randomly select 20 providers that have from the provider directory. Call these 20 providers between 7:00 pm and 10:00 pm to determine the after-hours care instructions that are available to enrollees. Do not request a provider call back.

**Documents to be Reviewed:**

- Policies and procedures or other documentation that demonstrate that the Plan has established standards and related goals for after-hours coverage.

| Item | Requirement |
|---|---|
| **AA-005** | **After-Hours Services**<br>The Plan's provisions for after-hours services are reasonable. |

- Reports that demonstrate that the Plan monitors after-hours coverage.
- Reports and corrective action plans that demonstrate that, if the Plan did not meet its goals for appointment availability in some or all of its service area, it has taken action to remedy those shortcomings and has re-measured.

**Individual(s)/Positions to be Interviewed:**

- Person responsible for maintaining the mental health network
- Person responsible for managing the triage and referral process
- Plan Director of Quality Improvement

*Level of Compliance:*

Met: All statutory/regulatory requirements are met.
Not Met: Some or not all statutory/regulatory requirements are met.

# UTILIZATION MANAGEMENT

| Item | Requirement |
|---|---|
| **UM-001** | **Medical Necessity Determination**<br>The Plan's or its Delegate's UM policies and procedures ensure that medical necessity decisions for parity mental health services (severe mental illnesses and serious emotional disturbances of children) are consistent with criteria or guidelines that are supported by sound clinical principles and processes. |
| | ***Statutory/Regulatory Citation(s):***<br>**CA Health and Safety Code 1374.72**<br>(a) Every health care service plan contract issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).<br>(b) These benefits shall include the following:<br>(1) Outpatient services.<br>(2) Inpatient hospital services.<br>(3) Partial hospital services.<br>(4) Prescription drugs, if the plan contract includes coverage for prescription drugs.<br>(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:<br>(1) Maximum lifetime benefits.<br>(2) Co-payments.<br>(3) Individual and family deductibles.<br>(d) For the purposes of this section, "severe mental illnesses" shall include:<br>(1) Schizophrenia.<br>(2) Schizoaffective disorder.<br>(3) Bipolar disorder (manic-depressive illness).<br>(4) Major depressive disorders.<br>(5) Panic disorder.<br>(6) Obsessive-compulsive disorder.<br>(7) Pervasive developmental disorder or autism.<br>(8) Anorexia nervosa.<br>(9) Bulimia nervosa.<br>(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected |

| Item | Requirement |
|---|---|
| UM-001 | **Medical Necessity Determination**<br>The Plan's or its Delegate's UM policies and procedures ensure that medical necessity decisions for parity mental health services (severe mental illnesses and serious emotional disturbances of children) are consistent with criteria or guidelines that are supported by sound clinical principles and processes. |

developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

**CA Health and Safety Code 1363.5(b)**

The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify or deny health care services shall:
(1) Be developed with involvement from actively practicing health care providers
(2) Be consistent with sound clinical principles and processes
(3) Be evaluated, and updated if necessary, at least annually

**CA Health and Safety Code 1367.01(b)**

These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes.

**CA Health and Safety Code 1367.01(f)**

The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes.

***Standards for Meeting Statutory/Regulatory Requirements:***

1. **Standard:** The Plan or its Delegate has written UM criteria that are objective, evidenced based and consistent with accepted standards of practice for the following mental health parity conditions:
   - Schizophrenia
   - Schizoaffective disorder
   - Bipolar disorder (manic depressive illness)
   - Major Depressive disorders
   - Panic disorder
   - Obsessive-compulsive disorder
   - Pervasive developmental disorder or autism
   - Anorexia Nervosa
   - Bulimia nervosa
   - Severe Emotional Disturbances of Children

| Item | Requirement |
|---|---|
| **UM-001** | **Medical Necessity Determination**<br>The Plan's or its Delegate's UM policies and procedures ensure that medical necessity decisions for parity mental health services (severe mental illnesses and serious emotional disturbances of children) are consistent with criteria or guidelines that are supported by sound clinical principles and processes. |

**Guidance:**

1.1 Determine whether Plan has written criteria for the diagnosis and treatment of serious mental illnesses including autistic disorders, other pervasive-developmental disorders and serious emotional disturbances of a child.

1.2 Determine the Plan's process for verifying or confirming the parity diagnosis including pervasive-developmental disorders (including autistic disorders) and child/adolescent's seriously emotionally disturbed (SED) status.

1.3 Interview at least one medical officer and one staff member responsible for the management of cases with pervasive developmental-related diagnoses to determine:

(a) what and how the Plan defines as medically necessary services for these disorders, and

(b) the circumstances under which an enrollee is referred to other resources(e.g., school district, regional center) to access services.

1.4 Interview the Medical Director or Associate Medical Director to determine:

(a) how the Plan accommodates enrollees whose serious mental illness might prevent them from complying with Plan requirements for pre-authorization prior to accessing medically necessary services; and

(b) the Plan's policy and process, if any, for disenrolling individuals that are not adherence to treatment, are disruptive, or pose a threat to providers.

**Documents to be Reviewed:**

- Criteria for the diagnosis and treatment of serious mental illnesses, autistic disorders, other pervasive-developmental disorders and serious emotional disturbances of a child.
- Policies and procedures for verifying parity diagnosis including pervasive-developmental disorders (e.g., autistic disorders) and serious emotional disturbances of a child.
- Policies and procedures related to individuals that are seriously mentally ill and are not adherent to Plan policies and procedures and/or treatment plans.

**Individual(s)/Positions to be Interviewed:**

UM Manager

Senior mental health clinical officer or medical director responsible for UM

| Item | Requirement |
|---|---|
| UM-001 | **Medical Necessity Determination**<br>The Plan's or its Delegate's UM policies and procedures ensure that medical necessity decisions for parity mental health services (severe mental illnesses and serious emotional disturbances of children) are consistent with criteria or guidelines that are supported by sound clinical principles and processes. |

2. **Standard:** Actively practicing mental health providers are involved in developing, adopting and reviewing criteria/guidelines used by the Plan or its Delegate to determine whether to authorize, modify or deny mental health services.

   **Guidance:**

   2.1 Review the UM or other designated committee's minutes to determine that the criteria/guidelines were either developed or reviewed by actively practicing mental health providers. The review panel must reflect the various disciplines involved in the care of a mental health consumer. The review panel should include at least a psychiatrist, child/adolescent psychiatrist or clinician with expertise treating children, and psychotherapists: MD, PhD, LCSW, and/or MFT.

   **Documents to be Reviewed:**

   - UM or other designated committee minutes

   **Individual(s)/Positions to be Interviewed:**

   - UM Manager
   - Senior mental health clinical officer or medical director responsible for UM

3. **Standard:** The Plan has policies and procedures for the application of criteria/guidelines supported by clinical principles to ensure consistent and appropriate medical necessity decision-making for the parity mental health diagnoses/conditions.

   **Guidance:**

   3.1 Review policies and procedures for the application of UM criteria/guideline by UM clinical staff (e.g., psychiatric nurse reviewer or RN/SW case managers).

   **Documents to be Reviewed:**

   - Policies and procedures for UM criteria/guideline development, adoption, annual review and updates

| Item | Requirement |
|---|---|
| **UM-001** | **Medical Necessity Determination**<br>The Plan's or its Delegate's UM policies and procedures ensure that medical necessity decisions for parity mental health services (severe mental illnesses and serious emotional disturbances of children) are consistent with criteria or guidelines that are supported by sound clinical principles and processes. |
| | **Individual(s)/Positions to be Interviewed:**<br>• UM Manager<br>• Senior mental health clinician responsible for UM |
| | ***Level of Compliance:*** |
| | Met: All statutory/regulatory requirements are met.<br>Not Met: Some or not all statutory/regulatory requirements are met. |

| Item | Requirement |
|---|---|
| UM-002 | **Appropriate Personnel**<br>Only a qualified licensed psychiatrist or a licensed health care professional that is competent to evaluate the specific clinical issues involved in the health care services requested by the provider may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. |

***Statutory/Regulatory Citation(s):***

**CA Health and Safety Code 1367.01(e)**

No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity.

***Standards for Meeting Statutory/Regulatory Requirements:***

1. **Standard:** Medical necessity decisions to modify or deny services are made only by appropriately licensed and trained psychiatrists and other licensed health care professionals that are competent to evaluate the specific clinical issues involved in the health care services requested by the provider (e.g., doctoral-level psychologists and doctoral level pharmacologists) acting within the scope of their licensure and competence.

**Guidance:**

1.1 Review the Plan/Delegate policies and procedures that describe the qualifications of UM staff that can approve and deny mental health services.

1.2 Randomly select:

- 20 UM medical necessity denials for mental health services (non-experimental) requested on behalf of enrollees with parity diagnoses, excluding autism, pervasive developmental delay and autism.
- 20 UM medical necessity denials for mental health services (non-experimental) requested on behalf of enrollees with parity diagnoses of autism or other forms pervasive developmental delay and seriously emotionally disturbed children.

Using the UM file review worksheet, review UM denial files to determine if appropriate mental health clinicians made the denial decisions.

**Documents to be Reviewed:**

- Plan/Delegate policies and procedures for UM decision-making.
- 20 UM medically necessity denial files for parity diagnoses, other than autism and pervasive developmental delay and seriously emotionally disturbed children.
- 20 UM medical necessity denial files for seriously emotionally disturbed children and for autism and pervasive developmental delay.

| Item | Requirement |
|---|---|
| **UM-002** | **Appropriate Personnel**<br>Only a qualified licensed psychiatrist or a licensed health care professional that is competent to evaluate the specific clinical issues involved in the health care services requested by the provider may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. |
| | **Individual(s)/Positions to be Interviewed:**<br>• UM Manager<br>• Senior mental health clinician responsible for UM |
| | ***Level of Compliance:***<br>Met: All statutory/regulatory requirements are met.<br>Not Met: Some or not all statutory/regulatory requirements are met. |

| Item | Requirement |
|---|---|
| UM-003 | **Communication of Coverage Decisions**<br>The Plan or its Delegate communicates the following to the requesting provider and the enrollee in its written UM determination:<br>• Written approval of provider requests specify the specific mental health services approved.<br>• The written determination to modify, delay, or deny services on the basis of medical necessity discloses the criteria used to make the decision.<br>• Denials based on benefits coverage must reference the specific provisions of the contract that exclude that coverage. |
| | ***Statutory/Regulatory Citation(s):*** |
| | **CA Health and Safety Code 1363.5(b)(4)**<br>If used as the basis of a decision to modify, delay, or deny services in a specified case under review, (the criteria shall) be disclosed to the provider and the enrollee in that specified case.<br><br>**CA Health and Safety Code 1367.01(h)(4) Safety Code 1367.01(h)(4)**<br>Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan‘s decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding clinical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan.<br><br>**CA Health and Safety Code 1368(a)(5)**<br>…If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.<br><br>**CA Health and Safety Code 1370.4(a)(1)(A-C)**<br>(a) Every health care service plan shall provide an external, independent review |

| Item | Requirement |
|---|---|
| UM-003 | **Communication of Coverage Decisions**<br>The Plan or its Delegate communicates the following to the requesting provider and the enrollee in its written UM determination:<br>• Written approval of provider requests specify the specific mental health services approved.<br>• The written determination to modify, delay, or deny services on the basis of medical necessity discloses the criteria used to make the decision.<br>• Denials based on benefits coverage must reference the specific provisions of the contract that exclude that coverage. |
| | process to examine the plan's coverage decisions regarding experimental or investigational therapies for individual enrollees who meet all of the following criteria:<br><br>(1)(A) The enrollee has a life-threatening or seriously debilitating condition.<br><br>(B) For purposes of this section, "life-threatening" means either or both of the following:<br><br>(i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.<br><br>(ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.<br><br>(C) For purposes of this section, "seriously debilitating" means diseases or conditions that cause major irreversible morbidity. |
| | ***Standards for Meeting Statutory/Regulatory Requirements:*** |
| | **1. Standard:** For all medical necessity denials, the Plan or Delegate provides a clear and concise response with an explanation of the reasons for the Plan' decision, a description of the criteria or guidelines used and the clinical reasons for the denial.<br><br>**Guidance:**<br>1.1 Review policies and procedures regarding denials and authorizations<br>1.2 Using the same UM file review worksheet and the same UM denial files selected in UM-002, review the files to determine if there is a clear and concise response with an explanation of the reasons for the Plan' decision, a description of the criteria or guidelines used and the clinical reasons for any medical necessity denial.<br><br>**Documents to be Reviewed:**<br>• Policies and procedures regarding UM decision-making.<br>• UM denial files selected under UM-002 |

| Item | Requirement |
|---|---|
| UM-003 | **Communication of Coverage Decisions**<br>The Plan or its Delegate communicates the following to the requesting provider and the enrollee in its written UM determination:<br>• Written approval of provider requests specify the specific mental health services approved.<br>• The written determination to modify, delay, or deny services on the basis of medical necessity discloses the criteria used to make the decision.<br>• Denials based on benefits coverage must reference the specific provisions of the contract that exclude that coverage. |
| | **Individual(s)/Positions to be Interviewed:**<br>• UM Director<br>• Medical Director or other senior clinical officer responsible for mental health<br><br>**2. Standard:** Written communication to the mental health provider requesting the service includes the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number is a direct number or an extension, to allow the requesting health care provider to easily contact the professional responsible for the denial, delay, or modification.<br><br>**Guidance:**<br>2.1 Using the same UM file review worksheet and the same UM denial files selected in UM-002, review the files to determine whether the Plan's written communication to the mental health provider requesting the service included the name and telephone number of the health care professional responsible for the denial, delay, or modification.<br><br>**Documents to be Reviewed:**<br>• UM medical necessity denial files selected under UM-002<br><br>**Individual(s)/Positions to be Interviewed:**<br>• See Standard 1 above<br><br>**3. Standard:** For any denial that is based in whole or in part on a finding that the requested service is not a covered benefit, the Plan clearly specifies in its written communications to enrollees and providers, the provisions in the contract that exclude that coverage.<br><br>**Guidance:**<br>3.1 Randomly select the following files:<br>• 20 UM denials made on the basis that the service is not a covered benefit for autism, pervasive developmental delay and other |

| Item | Requirement |
|---|---|
| UM-003 | **Communication of Coverage Decisions**<br>The Plan or its Delegate communicates the following to the requesting provider and the enrollee in its written UM determination:<br>• Written approval of provider requests specify the specific mental health services approved.<br>• The written determination to modify, delay, or deny services on the basis of medical necessity discloses the criteria used to make the decision.<br>• Denials based on benefits coverage must reference the specific provisions of the contract that exclude that coverage. |

diagnoses for seriously emotionally disturbed children.

- 20 UM denials made on the basis that the service is not a covered benefit for adults that have parity diagnoses.

Using the UM denial worksheet, determine whether the Plan clearly specified in its written communications to enrollees and providers, the provisions in the contract that exclude that coverage.

3.2 Verify that the denied benefits are consistent with the exclusions under the medical benefits.

3.3 Verify that limits placed on benefits are consistent with the limits placed on medical benefits.

**Documents to be Reviewed:**

- 20 UM denials made on the basis that the service is not a covered benefit for autism, pervasive developmental delay and other diagnoses for seriously emotionally disturbed children.
- 20 UM denials made on the basis that the service is not a covered benefit for adults that have parity diagnoses.

**Individual(s)/Positions to be Interviewed:**

- UM Director

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**4. Standard:** Written communication to an enrollee of a service request denial includes information as to how he/she may file a grievance or appeal.

**Guidance:**

4.1 Using the same UM file review worksheet and the same UM medical necessity and benefit denial files selected in UM-002 and UM-003, review the files to determine whether the Plan's written communication to an enrollee of a service request denial includes information as to how he/she may file a grievance or appeal.

**Documents to be Reviewed:**

- UM denial files selected under UM 003

| Item | Requirement |
|---|---|
| **UM-003** | **Communication of Coverage Decisions**<br>The Plan or its Delegate communicates the following to the requesting provider and the enrollee in its written UM determination:<br>• Written approval of provider requests specify the specific mental health services approved.<br>• The written determination to modify, delay, or deny services on the basis of medical necessity discloses the criteria used to make the decision.<br>• Denials based on benefits coverage must reference the specific provisions of the contract that exclude that coverage. |
| | **Individual(s)/Positions to be Interviewed:**<br>• See Standard 1 above<br><br>**5. Standard:** Written communication to an enrollee of a denial, delay or modification of a request on the basis that the requested service is not medically necessary or is experimental includes information concerning his / her right to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers.<br><br>**Guidance:**<br>5.1 Using the same UM file review worksheet and the same UM denial files selected in UM 002, review the files to determine whether the Plan's written communication to an enrollee of a denial, delay or modification of a request included information concerning his / her right to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers.<br><br>**Documents to be Reviewed:**<br>• See Documents to be reviewed under Standard 1 above<br><br>**Individual(s)/Positions to be Interviewed:**<br>• See Standard 1 above |
| | ***Level of Compliance:*** |
| | Met: All statutory/regulatory requirements are met.<br>Not Met: Some or not all statutory/regulatory requirements are met. |

| Item | Requirement |
|---|---|
| **UM-004** | **Claims Administration**<br>In paying claims, the Plan or its Delegate applies coverage limits, co-pays and coinsurance for parity mental health diagnoses/conditions consistent with the limits, co-payments and coinsurance for medical diagnoses and conditions. |

***Statutory/Regulatory Citation(s):***

**CA Health and Safety Code 1374.72**

(a) Every health care service plan contract issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:

(1) Maximum lifetime benefits.
(2) Copayments.
(3) Individual and family deductibles.

***Standards for Meeting Statutory/Regulatory Requirements:***

1. **Standard:** Limits on annual/lifetime maximum benefits, co-payments, individual and family deductibles for mental health services are consistent with or no more stringent than any limits placed on medical or surgical services.

   **Guidance:**

   1.1 There are rare instances wherein the medical benefits are more restrictive than the mental health benefits in terms of co-payments, deductibles, or covered services. Verify that limits for mental health services for enrollees with parity conditions and for SED children are no less stringent than any limits placed on medical or surgical services.

   1.2 Review the following sample of denied mental health claims for services rendered to enrollees with parity mental health diagnoses/conditions for evidence of inconsistency or disparity between mental health parity diagnoses/conditions and medical/surgical services.

   **Documents to be Reviewed:**

   - Policies and procedures, protocols documents relating any application of limits on the number of services inconsistent with those for medical or surgical services
   - Claim denial files:
     15 denied claims from non-participating ER with parity diagnoses
     15 denied claims from participating ERs with parity diagnoses
     15 denied non-ER claims for services with parity diagnoses, excluding

| Item | Requirement |
|---|---|
| **UM-004** | **Claims Administration**<br>In paying claims, the Plan or its Delegate applies coverage limits, co-pays and coinsurance for parity mental health diagnoses/conditions consistent with the limits, co-payments and coinsurance for medical diagnoses and conditions. |
| | autism, pervasive developmental delay and seriously emotionally disturbed children<br>15 denied non-ER claims for services for autism, pervasive developmental delay and seriously emotionally disturbed children<br><br>**Individual(s)/Positions to be Interviewed:**<br>• Mental health claims director/manager<br>• Senior mental health clinician responsible for mental health |
| | ***Level of Compliance:*** |
| | Met: All statutory/regulatory requirements are met.<br>Not Met: Some or not all statutory/regulatory requirements are met. |

| Item | Requirement |
|---|---|
| UM-005 | **Pharmacy Benefit Administration**<br>A Plan that provides prescription drug benefits and maintains a formulary applies the same terms and conditions to pharmacy benefits for enrollees with parity diagnoses. |

***Statutory/Regulatory Citation(s):***

**28 CCR 1300.74.72(h)**

Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription drugs.

**CA Health and Safety Code 1367.20**

Every health care service plan that provides prescription drug benefits and maintains one or more drug formularies shall provide to members of the public, upon request, a copy of the most current list of prescription drugs on the formulary of the plan by major therapeutic category, with an indication of whether any drugs on the list are preferred over other listed drugs. If the health care service plan maintains more than one formulary, the plan shall notify the requestor that a choice of formulary lists is available.

**CA Health and Safety Code 1367.24(a) and (b)**

(a) Every health care service plan that provides prescription drug benefits shall maintain an expeditious process by which prescribing providers may obtain authorization for a medically necessary nonformulary prescription drug. Each plan shall provide a written description of its most current process, including timelines, to its prescribing providers.

(b) Any plan that disapproves a request made pursuant to subdivision (a) by prescribing provider to obtain an authorization for a non-formulary drug shall provide the reasons for the disapproval in a notice provided to the enrollee. The notice shall indicate that the enrollee may file a grievance with the plan if the enrollee objects to the disapproval, including any alternative drug or treatment offered by the plan. The notice shall comply with subdivision (b) of Section 1368.02.

***Standards for Meeting Statutory/Regulatory Requirements:***

1. **Standard:** The Plan or Delegate involves psychiatrists, pediatricians and other mental health prescribing practitioners in the development of the formulary for psycho-pharmacologic drugs and pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution and step-therapy.

   **Guidance:**

   1.1 Pediatricians prescribe more for kids than child/adolescent psychiatrists because there are just more of them; so it is reasonable to require their input

   1.2 Review minutes of the Pharmacy and Therapeutics Committee or other

| Item | Requirement |
|---|---|
| **UM-005** | **Pharmacy Benefit Administration**<br>A Plan that provides prescription drug benefits and maintains a formulary applies the same terms and conditions to pharmacy benefits for enrollees with parity diagnoses. |

decision-making body to determine whether mental health prescribing clinicians, including pediatricians, have had input to the creation and periodic review of the Plan's formulary and pharmacy management processes.

1.3 Determine whether the Plan or its Delegate employs equally stringent processes when deciding which psychotropic drugs get included in the formulary and when deciding which non-psychotropic drugs are included.

1.4 Determine whether the Plan or its Delegate employs more stringent requirements for psychotropic drug coverage than for non-psychotropic drugs.

1.5 Determine whether the Plan or its Delegate applies the same utilization review policies in processing, approving, denying, and modifying requests for non-formulary drugs prescribed for enrollees with a parity diagnosis as it does for non-formulary drugs prescribed for enrollees with medical diagnoses.

1.6 Review 10 denials of non-formulary psychotropic medications for enrollees with parity condition/s. Determine whether the Plan or its Delegate applies the same utilization review policies in processing, approving, denying, and modifying requests for non-formulary drugs prescribed for enrollees with a parity diagnosis as it does for non-formulary drugs prescribed for enrollees with medical diagnoses.

**Documents to be Reviewed:**

- Pharmacy and Therapeutics Committee minutes
- Plan's formulary for psychotropic medications
- Provider Manual
- The Plan's Website, if the formulary information is posted on the website
- Pharmacy management procedures
- 10 denials of non-formulary psychotropic medications

**Individuals/Positions to be Interviewed**

- Senior mental health clinician
- Pharmacy Director

***Level of Compliance:***

Met: All statutory/regulatory requirements are met.
Not Met: Some or not all statutory/regulatory requirements are met.

| Item | Requirement |
|---|---|
| **UM-006** | **Triage and Referral**<br>If the Plan or its Delegate requires that an enrollee access the mental health system through a centralized triage and referral system, the Plan's or its Delegate's triage and referral system provides enrollees timely access and ready referral in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of parity conditions. |
| | ***Statutory/Regulatory Citation(s):*** |
| | **28 CCR 1300.74.72 (d) and (f)**<br><br>(d) A preliminary or initial diagnosis made by a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above, that the an enrollee has one or more conditions set forth in Health and Safety Code section 1375.72, shall constitute the diagnosis for the length of time necessary to make a final diagnosis, whether the final diagnosis confirms the initial or preliminary diagnosis.<br><br>(f) A plan's referral system shall provide enrollees timely access and ready referral in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72. |
| | ***Standards for Meeting Statutory/Regulatory Requirements:*** |
| | **1. Standard:** If the Plan or Delegate requires that an enrollee access the mental health delivery system through a centralized triage and referral system, the Plan's or Delegate's protocols for mental health triage and referral address the level of urgency and appropriate level of care relative to the enrollee's mental status and level of functioning.<br><br>**Guidance:**<br>1.1 Review the mental health triage and referral policies and procedures.<br>1.2 Determine whether enrollees calling the Triage Center are referred to a participating mental health practitioner in a timely and appropriate manner.<br>1.3 Determine how the Triage Center staff evaluate and manage enrollees that are in crisis when they call the Triage Center.<br><br>**Documents to be Reviewed:**<br>• Triage Policies and Procedures<br>• Review 10 cases from the Triage Center's telephone log, including at least 3 cases in which the enrollee required emergent care or urgent care. Verify that enrollees with parity conditions are referred to a qualified mental health practitioner in a timely and appropriate manner within the Plan or within the network. |

| Item | Requirement |
|---|---|
| **UM-006** | **Triage and Referral**<br>If the Plan or its Delegate requires that an enrollee access the mental health system through a centralized triage and referral system, the Plan's or its Delegate's triage and referral system provides enrollees timely access and ready referral in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of parity conditions. |

**Individual(s)/Positions to be Interviewed:**

- Senior mental health clinician responsible for triage and referral
  Triage Center Manager

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2. **Standard:** The Plan or Delegate reviews and updates protocols on parity conditions, when appropriate, on a regular basis.

**Guidance:**

2.1 Review the designated committee's minutes to determine that review and update occur at least annually.

**Documents to be Reviewed:**

- Triage Policies and Procedures
- Utilization Management Committee and/or work group meeting minutes

**Individual(s)/Positions to be Interviewed:**

- Mental health Medical Director
- Triage Center Personnel

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3. **Standard:** Licensed clinical staff members make decisions about the type and level of care to which enrollees are referred.

**Guidance:**

3.1. Review job descriptions of Triage Center's non-clinical and clinical personnel. Review protocols for referring enrollees to appropriate clinical personnel or practitioners within the network for initial evaluation.

3.2 Licensed practitioners or clinical personnel include qualified psychiatrists, RNs, psychologists, and master's prepared mental health therapists acting within the scopes of their licensure and competence

**Documents to be Reviewed:**

- Job descriptions of call center clinical and non-clinical personnel

| Item | Requirement |
|---|---|
| **UM-006** | **Triage and Referral**<br>If the Plan or its Delegate requires that an enrollee access the mental health system through a centralized triage and referral system, the Plan's or its Delegate's triage and referral system provides enrollees timely access and ready referral in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of parity conditions. |
| | **Individual(s)/Positions to be Interviewed:**<br>• Mental health Medical Director<br>• Triage Center Personnel<br><br>**4. Standard:** The Plan or its Delegate has contracts with practitioners, programs and facilities to provide services to enrollees that require urgent or emergent care.<br><br>**Guidance:**<br>4.1 This can include psychiatrists that are available to provide psychiatric evaluation on short notice, crisis treatment programs and hospitals that can provide evaluation and voluntary and involuntary inpatient admission.<br>4.2 Consult with the Access and Availability Surveyor on the information that the Plan provided for AA-002 and AA-003.<br>4.3 Interview staff to find out how the Triage Center determines when and where to refer the enrollee in a crisis situation.<br><br>**Documents to be Reviewed**<br>• Triage protocols for enrollees requiring immediate evaluation<br>• Three emergent or urgent cases of enrollees needing immediate evaluation (can use the same sample cases selected under Standard 1 above)<br><br>**Individual(s)/Positions to be Interviewed:**<br>• Mental health Medical Director<br>• Triage Center Personnel |
| | ***Level of Compliance:*** |
| | Met: All statutory/regulatory requirements are met.<br>Not Met: Some or not all statutory/regulatory requirements are met. |

| Item | Requirement |
|---|---|
| **UM-007** | **Emergency Services**<br>The Plan and/or its Delegate ensures that emergency mental health care services are available and accessible within the service area 24-hours-a-day, seven-days-a-week. |

***Statutory/Regulatory Citation(s):***

**CA Health and Safety Code 1374.72 (g)(2)**

A plan shall provide the mental health coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

**28 CCR 1300.74.72 (a)**

The mental health services required for the diagnosis and treatment of conditions set forth in Health and Safety Code section 1374.72 shall include, when medically necessary, all health services required under the act including, but not limited to, basic health services within the meaning of Health and Safety Code sections 1345(b) and 1367(i) and section 1300.67 of Title 28. These basic health care services shall at a minimum, include crisis intervention and stabilization, psychiatric inpatient services . . .

**28 CCR 1300.67.2(c)**

Emergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week.

**28 CCR 1300.67(g)(1)**

[The basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director may approve:…]

(g)(1) Emergency health care services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the health care service plan area. Emergency health care services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan.

**CA Health and Safety Code 1371.4(a)-(d)**

(a) A health care service plan, or its contracting medical providers, shall provide 24-hour access for enrollees and providers to obtain timely authorization for medically

| Item | Requirement |
|---|---|
| **UM-007** | **Emergency Services**<br>The Plan and/or its Delegate ensures that emergency mental health care services are available and accessible within the service area 24-hours-a-day, seven-days-a-week. |

necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision.

(b) A health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

***Standards for Meeting Statutory/Regulatory Requirements:***

1. **Standard:** The Plan or its Delegate has a process to receive notification of an emergency, emergency room evaluations and subsequent admissions, whether voluntary or involuntary, on a 24-hour-a-day basis.

| Item | Requirement |
|---|---|
| **UM-007** | **Emergency Services**<br>The Plan and/or its Delegate ensures that emergency mental health care services are available and accessible within the service area 24-hours-a-day, seven-days-a-week. |

**Guidance:**

1.1. Review the Plan's process for receiving notification of an emergency, including emergency room evaluations and admissions. This process must include having a psychiatrist available to prescribe and discuss safety plan and subsequent care arrangements with the emergency room/hospital staff and resolve disputes.

1.2. Determine how the Plan handles incoming telephone notification of an emergency. Determine whether the Plan has established criteria for emergency and urgent conditions. Evaluate whether the Plan consistently applies such criteria to determine whether a case is an emergency.

1.3. Determine how the Plan facilitates immediate or timely referral and evaluation of an enrollee in a crisis situation.

1.4. Evaluate whether there is a psychiatrist available on a 24-hour-a-day, 7 days-a-week basis to evaluate the need for admission and to resolve disputes regarding whether the enrollee is stable and can be transferred and/or discharged.

1.5. Evaluate whether the Plan or its Delegate pays for all psychiatric evaluations performed by a psychiatrist or masters-level mental health practitioner in the emergency room.

1.6. Evaluate whether the Plan or its Delegate pays for all involuntary admissions (5150 admissions).

1.7. Evaluate the Plan's requirements for a psychiatric evaluation or criteria to determine whether a client can be transferred or discharged after a voluntary or involuntary admission.

1.8 Evaluate whether the Plan or its Delegate pays for all emergency transportation for enrollees admitted involuntarily to the hospital.

**Documents to be Reviewed:**

- UM and Triage Center protocols for receiving and handling emergency room and emergency admission notifications
- UM and Triage Center protocols for authorizing emergency transportation for involuntary admissions
- UM and claims processing rules for payment of emergency room and emergency admissions, both voluntary and involuntary
- UM and claims processing rules for payment of emergency transportation for enrollees admitted involuntarily to the hospital
- Five most recent notifications of voluntary admission through the emergency room
- Five most recent notifications of involuntary admission through the

| Item | Requirement |
|---|---|
| UM-007 | **Emergency Services**<br>The Plan and/or its Delegate ensures that emergency mental health care services are available and accessible within the service area 24-hours-a-day, seven-days-a-week. |

emergency room
- Denied ER claims under UM 004

**Individual(s)/Positions to be Interviewed:**
- The senior mental health practitioner responsible for handling and reviewing emergency room services

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2. **Standard:** The Plan denies payment for emergency services rendered to enrollees with parity diagnosis/es only if the Plan reasonably determines that the emergency services and care were never performed or in cases where the Plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist using the prudent lay person rule.

**Documents to be Reviewed:**
- Denied ER claims under UM 004

**Guidance:**

2.1. Refer to the results of the ER claim denial file review conducted under UM 004 to determine whether the Plan inappropriately denies emergency service claims.

2.2. Review parity emergency service denial rates and compare them with medical emergency service denial rates. Determine whether there are untoward patterns and trends.

2.3. Continue the review of the ER denied claims under UM004 and determine whether the Plan paid for at least the evaluation if it was performed by a master's or higher level licensed clinician.

**Documents to be Reviewed:**
- UM policies for emergency services
- Claims processing guidelines for emergency service claims
- Denied ER claims under UM 004

**Individual(s)/Positions to be Interviewed:**
- Senior mental health practitioner responsible for UM
- UM Director

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3. **Standard:** If the Plan and the mental health provider (which is in-area) that

| Item | Requirement |
|---|---|
| **UM-007** | **Emergency Services**<br>The Plan and/or its Delegate ensures that emergency mental health care services are available and accessible within the service area 24-hours-a-day, seven-days-a-week. |

provided emergency services disagree regarding the need for continued care of the enrollee after stabilization, the Plan assumes responsibility for the care of the patient either by having mental health care personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another hospital with mental health care facilities under contract with the Plan agree to accept the transfer of the patient.

**Guidance:**

3.1. Review policies and procedures on timely authorization for medically necessary care for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely.

3.2. Review policies and procedures/protocols for instances in which the Plan and the provider disagree regarding the need for necessary mental health care following stabilization of the enrollee. The Plan should assume responsibility for the care of the patient by either having mental health care personnel contracting with the Plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another hospital with mental health care facilities under contract with the Plan agree to accept the transfer of the patient.

**Documents to be Reviewed:**

- Policies and procedures/protocols for instances in which the Plan and the provider disagree regarding the need for necessary mental health care following stabilization of the enrollee.

**Individual(s)/Positions to be Interviewed:**

- Senior mental health clinical officer responsible for UM
- UM Director
- Case Management Staff Member

***Level of Compliance:***

Met: All statutory/regulatory requirements are met.
Not Met: Some or not all statutory/regulatory requirements are met.

# CONTINUITY AND COORDINATION OF CARE

| Item | Requirement |
|---|---|
| **CC-001** | **Exchange of Information and Collaboration Between and Among Medical and Mental Health Providers**<br>The Plan monitors and improves the exchange of information between and among medical and mental health providers. |

***Statutory/Regulatory Citation(s):***

**28 CCR 1300.74.72(g)(3)-(4)(A)**

(3)The Plan shall monitor the continuity and coordination of care that enrollees receive, and take action, when necessary, to assure continuity and coordination of care, in a manner consistent with professionally recognized evidence-based standards of practice, across the health care network**.**

(4) the plan shall monitor, as often as necessary, but not less frequently than once every year, the collaboration between medical and mental health providers, but not limited to, the following:

(A) exchange of information….

***Standards for Meeting Statutory/Regulatory Requirements:***

1. **Standard:** The Plan and Delegate have processes to facilitate timely communication between and among an enrollee's mental health providers and between an enrollee's medical and mental health providers. At a minimum, these processes include:
   - Communication among providers between levels of care (e.g., inpatient care, partial hospitalization, outpatient care, day and residential treatment);
   - Communication between and among mental health providers; and
   - Communication between and among the enrollee's mental health providers (e.g., psychiatrist, psychologist, and master's-level mental health clinicians) and medical providers (e.g., PCP, specialists)
   - Communication between and among Plan's case management clinical staff
   - Communication between and among Plan's and facility's case management clinical staff (if two or more case managers are involved within the Plan)
   - Communication between and among Plan's and Delegate's case management clinical staff
   - Communication between and among IPA/medical groups and Plan's/Delegate's case management staff

**Guidance**

1.1 Review the Plan's or Delegate's policies and procedures

| Item | Requirement |
|---|---|
| **CC-001** | **Exchange of Information and Collaboration Between and Among Medical and Mental Health Providers**<br>The Plan monitors and improves the exchange of information between and among medical and mental health providers. |

regarding continuity, timeliness, and coordination of care between and among mental health providers and other mental health practitioners.

1.2 Review the Plan and/or the Delegate policies and procedures that require continuity and coordination of care between and among medical and mental health providers, e.g., between PCP and treating psychiatrist

1.3 Review the Plan and/or the Delegate policies and procedures that require continuity and coordination of care between and among IPA's/medical groups and facility case management clinical staff

1.4 Review the Plan and/or the Delegate policies and procedures that facilitates continuity and coordination of care when an enrollee is out-of-area and/or out-of-network.

1.5 Review 20 case management files to evaluate how case managers coordinate care within the mental health system and between mental health and medical care.

**Documents to be Reviewed:**

- Policies and procedures of the Plan and Delegate, if applicable, on continuity and coordination of mental health services and between primary care and mental health services.
- Documentation that the Plan and/or Delegate has distributed the policies and procedures or other appropriate documentation to participating mental health and medical providers (e.g., PCPs and other medical providers), as applicable.
- 20 case management files

**Individual(s)/Positions to be Interviewed:**

- Plan Medical Director
- The Delegate Mental Health Medical or Clinical Director
- Plan Director of Quality Improvement
- The Delegate Director of Quality Improvement, if applicable

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**2. Standard:** The Plan or Delegate measures the exchange of information and its effectiveness between levels of care and/or types of providers at least annually. At least one measure evaluates communication between an enrollee's primary mental health provider and the enrollee's primary care physician.

| Item | Requirement |
|---|---|
| **CC-001** | **Exchange of Information and Collaboration Between and Among Medical and Mental Health Providers**<br>The Plan monitors and improves the exchange of information between and among medical and mental health providers. |

**Guidance:**

2.1. Review documentation that the Plan and/or its Delegate has established continuity, timeliness and coordination of care performance indicators

2.2. Review documentation that, at least annually, the Plan and/or its Delegate measures the performance of its mental health providers and clinicians and primary care physicians exchanging pertinent information in a timely manner.

**Documents to be Reviewed:**

- Performance indicators regarding continuity and coordination of care
- Reports demonstrating measurement of performance indicators

**Individual(s)/Positions to be Interviewed:**

- The Plan Medical Director
- The Mental Health Medical or Clinical Director
- Plan Director of Quality Improvement
- The Delegate Director of Quality Improvement, if applicable

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**3. Standard:** The Plan or Delegate analyzes the exchange of information data among participating providers. If the Plan identifies deficiencies in its performance, it takes action to improve performance.

**Guidance:**

3.1 Review the Plan's analysis performance data to identify the causes of poor performance.

3.2 Review documentation of the interventions that the Plan and/or it Delegate implemented to improve the exchange of information.

**Documents to be Reviewed:**

- Analysis of the results of performance measurement and activities undertaken to improve performance
- Quality Improvement Committee and/or work group meeting minutes
- Reports of continuity and coordination of care measures, results,

| Item | Requirement |
|---|---|
| **CC-001** | **Exchange of Information and Collaboration Between and Among Medical and Mental Health Providers**<br>The Plan monitors and improves the exchange of information between and among medical and mental health providers. |
| | analyses, conclusions and actions to be taken<br>• Corrective action plans<br>• Documentation of interventions and results<br><br>**Individual(s)/Positions to be Interviewed:**<br>• The Plan Medical Director<br>• The Mental Health Medical or Clinical Director<br>• Plan Director of Quality Improvement<br>• The Delegate Director of Quality Improvement, if applicable |
| | ***Level of Compliance:***<br>Met: All statutory/regulatory requirements are met.<br>Not Met: Some or not all statutory/regulatory requirements are met. |

| Item | Requirement |
|---|---|
| **CC-002** | **Appropriate and Timely Diagnosis, Treatment and Referral of Enrollees with Parity Mental Health Conditions**<br>The Plan ensures that the care delivered to enrollees with parity diagnoses across the health care network meets professionally recognized evidence-based standards of practice. |

***Statutory/Regulatory Citation(s):***

**28 CCR 1300.70(b)(2)(C)**

Each plan's QA program shall meet all of the following requirements: ….
(C) The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. . . .

**28 CCR 1300.74.72(g)(3)…(4)(B)**

(3)The plan shall monitor the continuity and coordination of care that enrollees receive, and take action, when necessary, to assure continuity and coordination of care, in a manner consistent with professionally recognized evidence-based standards of practice, across the health care network**.**

(4) the plan shall monitor, as often as necessary, but not less frequently than once every year, the collaboration between medical and mental health providers, but not limited to, the following : ...

(B) appropriate diagnosis, treatment and referral….

***Standards for Meeting Statutory/Regulatory Requirements:***

1. **Standard:** The Plan or Delegate adopts evidence-based clinical practice guidelines or protocols for one or more parity mental health conditions and distributes the clinical practice guidelines to mental health providers, primary care physicians and specialty providers, as appropriate.

   **Guidance:**
   **Note:** Parity mental health conditions may be treated in both primary care and mental health settings. It is important that both mental health and primary care providers diagnose, treat and refer enrollees that have one or more of the parity mental health conditions in a timely and appropriate manner.

| Item | Requirement |
|---|---|
| **CC-002** | **Appropriate and Timely Diagnosis, Treatment and Referral of Enrollees with Parity Mental Health Conditions**<br>The Plan ensures that the care delivered to enrollees with parity diagnoses across the health care network meets professionally recognized evidence-based standards of practice. |

1.1 Review the Plan's clinical practice guidelines or protocols for mental health parity conditions. The clinical practice guidelines must include the following information, as appropriate:
- Criteria for diagnosing the condition;
- Algorithm for treating the condition, including referral to a specialist, as appropriate;
- The scientific basis for the clinical practice guideline

1.2 Review documentation that the Plan and/or its Delegate, as appropriate, has distributed the clinical practice guidelines to the Plan's primary care and other medical physicians and mental health providers.

1.3 Review referral guidelines between and among medical and mental health providers, e.g., between PCP and mental health providers, between psychiatrist and other mental health providers (e.g., LCSW, clinical psychologist, or MFT)

**Documents to be Reviewed:**
- Clinical practice guidelines
- Documentation that the Plan and/or the Delegate have distributed the clinical practice guidelines (e.g., via provider manuals, special mailings, provider newsletters)
- Minutes of collaborative committee meetings
- Educational/training materials for practitioners
- Web based tools to detect and refer co-existing conditions among enrollees
- Analyses to detect epidemiological evidence of co-existing disorders and relevance to enrollment

**Individual(s)/Positions to be Interviewed:**
- The Plan Medical Director
- The Mental Health Medical or Clinical Director
- Plan Director of Quality Improvement
- The Delegate Director of Quality Improvement, if applicable

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2. **Standard:** As part of its quality improvement program, the Plan annually measures and analyzes mental health provider performance against one or more of its established parity mental health clinical practice guidelines, using

| Item | Requirement |
|---|---|
| **CC-002** | **Appropriate and Timely Diagnosis, Treatment and Referral of Enrollees with Parity Mental Health Conditions**<br>The Plan ensures that the care delivered to enrollees with parity diagnoses across the health care network meets professionally recognized evidence-based standards of practice. |

a statistically valid methodology. If the data indicate that there are opportunities to improve performance, the Plan and its Delegate, if applicable, take appropriate action to improve performance.

**Guidance:**

2.1 Review the QI program. Verify that Plan has mechanism to measure provider performance against practice guidelines.

2.2 Review the description of the methodology the Plan uses to measure performance against the parity mental health clinical practice guideline(s).

2.3 Review the results of the performance measurement for the two most recent measurement periods.

2.4 Review documentation that demonstrates that the Plan has taken action to improve performance.

**Documents to be Reviewed:**

- The description of the performance measurement methodology
- Documentation of the results of the performance measurement for the two most recent measurement periods
- Analysis of the results of performance measurement and activities undertaken to improve performance
- Quality Improvement Committee and/or work group meeting minutes

**Individual(s)/Positions to be Interviewed:**

- The Plan Medical Director
- The Mental Health Medical or Clinical Director
- Plan Director of Quality Improvement
- The Delegate Director of Quality Improvement, if applicable

***Level of Compliance:***

Met: All statutory/regulatory requirements are met.
Not Met: Some or not all statutory/regulatory requirements are met.

**SURVEY AREA**:

| Item | Requirement |
|---|---|
| **CC-003** | **Coordination of Care for Enrollees with Co-existing Medical and Mental Health Parity Disorders**<br>The Plan facilitates treatment and coordination of care for those enrollees that have both medical and mental health disorders. |
| | ***Statutory/Regulatory Citation(s):*** |
| | **28 CCR 1300.74.72(g)(4)**<br>The plan shall monitor, as often as necessary, but not less frequently than once every year, the collaboration between medical and mental health providers, including, but not limited to the following…<br><br>(C) access to treatment and follow-up for enrollees with co-existing medical and mental health disorders. |
| | ***Standards for Meeting Statutory/Regulatory Requirements:*** |
| | **1. Standard:** The Plan and/or its Delegate have established mechanisms to identify and refer enrollees that have co-existing conditions.<br><br>**Guidance:**<br>**Note:** "Co-existing condition" means a condition in which a person presents with both mental and medical diagnoses.<br><br>It is common to find parity diagnosis among persons suffering from chronic disabling conditions. For example, persons with disabling congestive heart failure or severe arthritis are often diagnosed with a serious mental illness, e.g., major depression. It is also common to identify persons with parity conditions in an acute medical hospital. A typical example of this is when an adolescent is admitted to a hospital for severe dehydration or fluid and electrolyte imbalance and is eventually diagnosed with anorexia nervosa.<br>1.1 Review policies on collaboration between the medical and mental health delivery systems to ensure effective co-management of enrollees that have co-existing medical and mental health conditions.<br>1.2 Review program descriptions regarding collaborative projects between the medical and mental health delivery systems that are designed to ensure that enrollees that have co-existing medical and mental health conditions are treated and followed-up in a timely manner.<br>1.3 Review disease management programs for collaborative efforts between the disease management program and the mental health delivery system to identify enrollees that are enrolled in disease management programs that have co-existing mental health conditions. |

| Item | Requirement |
|---|---|
| **CC-003** | **Coordination of Care for Enrollees with Co-existing Medical and Mental Health Parity Disorders**<br>The Plan facilitates treatment and coordination of care for those enrollees that have both medical and mental health disorders. |

1.4 Review case management programs for collaborative efforts between the medical and mental health delivery systems to identify enrollees that that have co-existing mental health conditions.

**Documents to be Reviewed:**

- Plan's and Delegate's, if applicable, policies and procedures on screening for and co-management of co-existing medical and mental health conditions
- Practitioner and provider manuals
- Quality Improvement Committee minutes, task force meeting minutes
- Disease Management Program
- Case Management Program

**Individual(s)/Positions to be Interviewed:**

- The Plan Medical Director
- The Mental Health Medical or Clinical Director
- Plan Director of Quality Improvement
- The Delegate Director of Quality Improvement, if applicable

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**2**. **Standard:** The Plan has established a system to monitor, at least annually, how effectively medical and mental health providers screen enrollees for co-existing conditions and ensure access to treatment and follow-up.

**Guidance:**

2.1 Review the methodology that the Plan and/or its Delegate has put in place to monitor how well its mechanisms to identify and coordinate care for enrollees that have coexisting medical and mental health conditions work. Examples include:

- the number and percent of enrollees receiving disease management services that were screened for depression and the number and percent of those screened that completed a referral for treatment of depression;
- the number and percent of enrollees under treatment for schizophrenia that are screened for weight management and hyperglycemia;
- the number and percent of enrollees in medical case

| Item | Requirement |
|---|---|
| **CC-003** | **Coordination of Care for Enrollees with Co-existing Medical and Mental Health Parity Disorders**<br>The Plan facilitates treatment and coordination of care for those enrollees that have both medical and mental health disorders. |

management that are screened for mental health conditions and are co-managed, as applicable, with the mental health case managers; and

- the percent of members that were hospitalized for medical conditions and exhibited psychiatric symptomology (e.g., confusion, dementia, anxiety, depression) that received psychiatric consultation on a timely basis.

**Documents to be Reviewed:**

- Documentation of the methodology used to monitor mechanisms to identify and coordinate care for enrollees that have coexisting medical and mental health conditions
- Disease management program descriptions
- Descriptions of the mental health and medical case management systems and mechanisms for co-management

**Individual(s)/Positions to be Interviewed:**

- The Plan Medical Director
- The Mental Health Medical or Clinical Director
- Plan Director of Quality Improvement
- The Delegate Director of Quality Improvement, if applicable

***Level of Compliance:***

Met: All statutory/regulatory requirements are met.
Not Met: Some or not all statutory/regulatory requirements are met.

| Item | Requirement |
|---|---|
| **CC-004** | **Transitions of Care**<br>The Plan has mechanisms to facilitate transitions of care when (a) an individual that is in a course of mental health treatment enrolls in the Plan or (b) when a mental health provider that has enrollees under care terminates participation with the Plan. |
| | ***Statutory/Regulatory Citation(s):*** |
| | **28 CCR 1300.74.72(g)(3)**<br><br>…the plan shall monitor the continuity and coordination of care that enrollees receive, and take action, when necessary, to assure continuity and coordination of care, in a manner consistent with professionally recognized evidence-based standards of practice, across the health care network;<br><br>**CA Health and Safety Code 1373.95(b)(2)**<br><br>The plan shall file with the department a written policy describing the manner in which it facilitates the continuity of care for new enrollee who has been receiving services from a non-participating mental health provider for an acute, serious, or chronic mental health condition when his or her employer changed health plans. The written policy shall allow the new enrollee a reasonable transition period to continue his or her course of treatment with the non-participating mental health provider prior to transferring to a participating provider and shall include the provision of mental health services on a timely, appropriate, and medically necessary basis from the non-participating provider. The policy may provide that the length of the transition period take into account on a case by case basis, the severity of the enrollee's condition and the amount of time reasonably necessary to effect a safe transfer. The policy shall ensure that the reasonable consideration is given to the potential clinical effect of a change of provider on the enrollee's treatment for the condition. The policy shall describe the plan's process to review an enrollee's request to continue his or her treatment with a non-participating mental health provider. Nothing in this paragraph shall be construed to require the plan to accept non-participating mental health provider onto its panel for treatment of other enrollees. For purposes of the continuing treatment of the transferring enrollee, the plan may require the non-participating mental health provider, as a condition of the right conferred under this section, to enter into its standard mental health provider contract.<br><br>**CA Health and Safety Code 1373.96 (a), (b)(1), and (c)(1) and (2)**<br><br>(a) A health care service plan shall at the request of an enrollee, provide the completion of covered services as set forth in this section by a terminated provider by a nonparticipating provider.<br><br>(b)(1) The completion of covered services shall be provided by a terminated provider to an enrollee who at the time of the contract's termination , was |

receiving services from that provider for one of the conditions described in subdivision (c);

(c) The health care service plan shall provide for the completion of covered services for the following conditions:

(1) An acute condition . An acute condition is a medical condition that involves a sudden on set of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

(2) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over a an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider…and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date….

*Standards for Meeting Statutory/Regulatory Requirements:*

1. **Standard:** The Plan has mechanisms to assist new enrollees that are receiving services from a nonparticipating mental health provider for an acute, serious, or chronic mental health condition in transitioning care to a participating clinician. These mechanisms include:
   - (a) allowing the enrollee to stay with previous mental health provider for a specified period of time;
   - (b) assisting the enrollee in choosing a participating mental health provider; and
   - (c) facilitating communication between the previous mental health provider and the new mental health clinician.

   **Guidance:**

   1.1 Review documentation that the Plan and/or its Delegate have a process to assist enrollees in transitioning to a new mental health clinician when enrolling in the Plan.

   1.2 Review the criteria that the Plan and/or its Delegate use to determine whether an enrollee needs to continue treatment with a nonparticipating provider. At a minimum this should include that the enrollee is receiving treatment for an acute, serious, or chronic mental health condition that, if discontinued with the current practitioner, could cause a relapse or worsening of the condition being treated. If said treatment is occurring less frequently than weekly, it typically would not qualify as requiring a transition period, with the exception of maintenance

ECT.

1.3 Review documentation that Member/Customer Services has appropriate information to inform new enrollees about how to request transition services.

1.4 Review documentation that the Plan and/or its Delegate has implemented the transition of care process for new enrollees.

1.5 Review of documentation and questions posed during interviews should be directed toward both the Plan and its Delegate.

**Documents to be Reviewed:**

- Plan and/or Delegate policies and procedures on transitions of care, including the criteria used to determine if the enrollee needs to continue with the nonparticipating provider.
- Member/Customer Services computer screens/desk procedures on responding to inquiries about transition of care

**Individual(s)/Positions to be Interviewed:**

- Member/Customer Services Director
- Staff person responsible for assisting enrollees in transitioning care

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**2. Standard:** The Plan has mechanisms to assist enrollees that are receiving treatment for an acute or chronic mental health condition when their mental health clinician terminates participation in the Plan to transition to a participating mental health provider.

**Guidance:**

2.1 In situations where the reason for provider termination is not quality related, and the enrollee receiving treatment for an acute or chronic condition, and the mental health clinician is willing to accept the current fee agreement, and the enrollee wishes to continue the relationship, the Plan has a process that includes:

(a) allowing the enrollee to stay with the current mental health provider for through the course of treatment for the acute condition or for up to 12 months for a chronic condition

(b) assisting the enrollee in choosing a new participating mental health provider; and

(c) facilitating communication between the previous mental health provider and the new mental health provider.

2.2 Review policies and procedures regarding assisting enrollees when their mental health terminates participation in the Plan.

2.3 Review the criteria that the Plan/Delegate uses to determine if the enrollee should stay in treatment for a defined period of time with the terminated provider. At a minimum this should include

that the enrollee is receiving treatment for an acute or chronic mental health condition that, if discontinued with the current practitioner, could cause a relapse or worsening of the condition being treated. If said treatment is occurring less frequently than weekly, it typically would not qualify as requiring a transition period, with the exception of maintenance ECT.

**Documents to be Reviewed:**

- Policy regarding transition of care
- Definition of active treatment
- Notification letters to enrollees requesting transitional care
- Reports on number, type and disposition of transitional care cases

**Individual(s)/Positions to be Interviewed:**

- Individual Case Management Director

***Level of Compliance:***

Met: All statutory/regulatory requirements are met.
Not Met: Some or not all statutory/regulatory requirements are met.

| Item | Requirement |
|---|---|
| **CC-005** | **Analysis of Grievances and Appeals**<br>The Plan regularly conducts an aggregate analysis of grievances related to parity mental health services to identify barriers to care. |

***Statutory/Regulatory Citation(s):***

**CCR 1300.68 (e)**

(e) The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances. The system shall:

(1) Monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the enrollee or plan; and the number of grievances pending over 30 calendar days. The system shall track grievances under categories of Commercial, Medicare and Medi-Cal/other contracts. The system shall indicate whether an enrollee grievance is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) an action filed or before a trial or appellate court; or (5) other dispute resolution process. Additionally, the system shall indicate whether an enrollee grievance has been submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal fair hearing process; or (3) arbitration.

(2) The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) disputes involving medical necessity, (3) complaints about the quality of care and (4) complaints about access to care (including complaints about the waiting time for appointments), and (5) complaints about the quality of service, and (6) other issues.

**CA Health and Safety Code 1367.01(j)**

(j) Every health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

***Standards for Meeting Statutory/Regulatory Requirements:***

1. **Standard:** The Plan regularly conducts aggregate analysis of grievances and appeals to track and trend potential parity-related issues and barriers to care.

**Guidance:**

1.1 Review the report on the analysis of grievances covering the most recent 12 month period to verify that it includes consideration of issues relevant to mental health parity including:
- timely access,
- access to all necessary services,
- availability of appropriate providers and practitioners, and
- appropriateness of benefit limits, copayments, and deductibles.

1.2 Review minutes of the Quality Management or other appropriate governance committee in which the analysis of grievances was discussed to verify that the committee's deliberations included specific attention to issues relevant to mental health parity.

**Documents to be reviewed:**
- Reports on Analysis of Grievances for most recent 6-12 month period.
- Minutes of governance committee in which above reports were discussed.

**Individual(s)/Positions to be Interviewed:**
- Manager of Member/Customer Service or other Plan staff member responsible for analysis of complaints.

***Level of Compliance:***

Met: All statutory/regulatory requirements are met.
Not Met: Some or not all statutory/regulatory requirements are met.

# DELEGATION MONITORING

| Item | Requirement |
|---|---|
| **DM-001** | **Delegation Monitoring**<br>If a plan contracts with a specialized health care service plan or one or more medical groups for the purpose of providing Health and Safety Code section 1374.72 services, it regularly monitors the delegate's performance and its compliance with all standards related to Benefit Structure and Enrollee Information, Access and Availability of Services, Utilization Management and Quality Management as presented in this Technical Assistance Guide. |
| | **CA Health and Safety Code 1374.72(g)(1)**<br>For purposes of compliance with this section, a plan may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.<br><br>**28 CCR 1300.74.72(g)(3) and (4)**<br>If a plan contracts with a specialized health care service plan for the purpose of providing Health and Safety Code section 1374.72 services, the following requirements shall apply:<br>(3) the plan shall monitor the continuity and coordination of care that enrollees receive, and take action, when necessary, to assure continuity and coordination of care, in a manner consistent with professionally recognized evidence-based standards of practice, across the health care network.<br>(4) the plan shall monitor, as often as necessary, but not less frequently than once a year, the following collaboration between medical and mental health providers including, but not limited to, the following:<br>(A) exchange of information,<br>(B) appropriate diagnosis, treatment and referral, and<br>(C) access to treatment and follow-up for enrollees with co-existing medical and mental health disorders.<br><br>**CA Health and Safety Code 1367.01(a)**<br>A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively or concurrently with, the provision of health care services to enrollees, or that delegated these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.<br><br>**28 CCR 1300.70(b)(2)(G)(1)-(4)**<br>Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. |

**28 CCR 1300.70(b)(2)(C)**

Each plan's QA program shall meet all of the following requirements: ….
(B) Written documents shall delineate QA authority, function and responsibility, and provide evidence that the plan has established quality assurance activities and that the plan's governing body has approved the QA Program. To the extent that a plan's QA responsibilities are delegated within the plan or to a contracting provider, the plan documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.

***Standards for Meeting Statutory/Regulatory Requirements:***

1. **Standard:** There is a mutually agreed upon contract and/or delegation agreement between the Plan and the entity to which the Plan has delegated management of mental health benefits that includes, but not limited to the following:
   (a) A clear statement of the mental health benefits to be provided to the Plan's enrollees;
   (b) A description of the mental health delegated services and activities;
   (c) A delineation of the administrative responsibilities of the Plan and the Delegate, including specification of responsibility for grievances and appeals and for the customer service telephone line for handling of enrollees' inquiries about benefits;
   (d) A description of the requirement for the Delegate to collaborate with the Plan on: (1) improving the exchange of information between medical and mental health providers, (2) improving the diagnosis, treatment and referral of mental health conditions in medical settings; (3) improving access to treatment and follow-up for enrollees with co-existing medical and mental health disorders; (4) improving transition of care; (5) improving ambulatory follow-up care.

**Guidance:**

1.1 Review the subcontract, delegation agreement or other materials that the Plan has provided to the Delegate to verify that all six requirements listed above are covered.

**Documents to be Reviewed:**

- Plan to Plan Contract (between full service plan and mental health plan contract) or Delegation agreement; and
- Other materials provided by the Plan to the Delegate to delineate responsibilities and monitoring activities.

**Individual(s)/Positions to be Interviewed:**

- Plan staff person responsible for the delegation
- Delegate staff person responsible for the delegation

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|---|---|
| | ***Level of Compliance:*** |
| | Met: All statutory/regulatory requirements are met. |
| | Not Met: Some or not all statutory/regulatory requirements are met. |